

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS5423AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>EXCELLENT ADULT CARE SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8280 HICKAM AVE</b> <b>LAS VEGAS, NV 89129</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 000	Initial Comments  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 11/30/10 to 2/23/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a re-survey grade of B.  The following deficiencies were identified:	Y 000			
Y 870 SS=E	449.2742(1)(a)(1)(2)(b)(c) Medication Administration  NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident. (2) Provides a written report of that review to the administrator of the facility; (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the	Y 870			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS5423AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>EXCELLENT ADULT CARE SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8280 HICKAM AVE</b> <b>LAS VEGAS, NV 89129</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 879	<p>Continued From page 3</p> <p>Findings include:</p> <p>Resident #3 was prescribed Seroquel 50 mg , 1 tab at bedtime by her physician for depression.</p> <p>Upon review on the Medications Administration Record, it was noted that the Seroquel for Resident #3 was not administered for six days from 11/24/10 through 11/30/10.</p> <p>Employee #1 stated the medication could not be refilled because the resident was seeing a new physician and that the new physician had not signed off on the medication order for the new order of Seroquel.</p> <p>Employee #1 stated attempts were made by phone to contact the resident's previous physician in order to have the prescription sent to the new physician approve the order. But the doctor would not return phone calls to the facility. The facility could not provide proof of any fax notices sent to the resident 's physician notifying the doctor 's office of any missed medication dosages.</p> <p>On 11/30/10, the pharmacy was called and stated medication had not been signed off by the resident's new physician. The pharmacist contacted the doctor's office and were able to attain the signed medication order on 11/30/10. The pharmacist assured the medication would be ready to be picked-up by 12/1/10.</p> <p>Employee #1 sent proof of delivered medication on 12/1/10, which indicated the prescription for Seroquel were received.</p> <p>Severity: 3 Scope: 2</p>	Y 879			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS5423AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>EXCELLENT ADULT CARE SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8280 HICKAM AVE</b> <b>LAS VEGAS, NV 89129</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 883	Continued From page 4	Y 883			
Y 883 SS=E	449.2742(7) Medication / Resident Refusal  NAC 449.2742 7. If a resident refuses, or otherwise misses, and administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.  This Regulation is not met as evidenced by: Based on interview and record review on 11/30/10, the administrator failed to ensure 1 of 3 resident physicians were notified within 12 hours after a dose of medication was missed or refused (Resident #3).  Severity: 2 Scope: 2	Y 883			
Y9999	Final Observations  Based on observation and interview from 11/30/10 to 2/23/11, the facility did not have an administrator licensed by the Board of Examiners for Long Term Care Administrators to provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services.  Severity: 2 Scope: 3	Y9999			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.